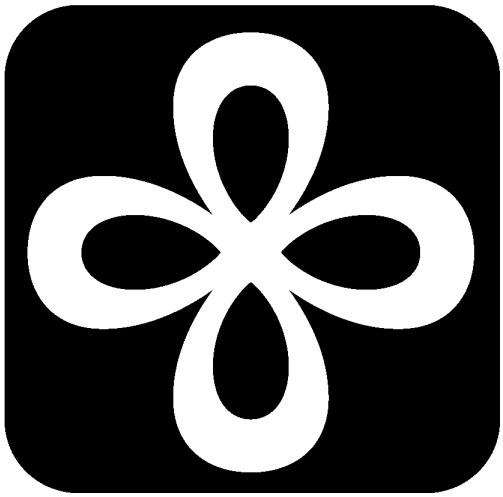
STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

MEDICAID



Provider Manual

Ambulance Services

CHAPTER E. COVERAGE AND LIMITATIONS Page

CHAPTER F. BILLING AND PAYMENT

APPENDIX

I. CONDITIONS FOR PARTICIPATION

To be eligible to participate in the Medicaid program, an ambulance service must meet certain standards of quality with respect to both vehicle, staff, and billing and reporting requirements. These standards are identical to those in effect in the Medicare program.

There are two levels of ambulance service:

- Basic life support and
- Advanced life support.

Basic life support means at least one member of the ambulance crew is certified at the basic EMT level and is trained in:

- Patient assessment.
- Recognition of signs and symptoms regarding illness and injury.
- The use of proper procedures when rendering basic emergency medical care.

Advanced life support means that at least one member of the ambulance crew is additionally certified to provide emergency procedures. At a minimum these include defibrillation or synchronized cardioversion. They may also include administration of intravenous solutions, intubation, and administration of emergency drugs.

II. COVERAGE OF SERVICES

The following sections explain coverage limits related to:

- General guidelines for ambulance transport.
- Demonstrating medical necessity for emergency transportation.
- Demonstrating medical necessity for nonemergency transportation.
- Exclusions and limitations of Medicaid coverage.
- Transfer from one nursing facility to another.

A. Ambulance Transport Guidelines

Medicaid will pay for ambulance transportation by an approved ambulance service to a hospital or skilled nursing facility only when transportation by any other means could endanger the patient's health.

In order to receive payment, the provider must document the medical necessity of this transport on the claim or run report. It is the responsibility of the ambulance supplier to furnish complete and accurate documentation to demonstrate that the ambulance service being furnished meets the medical necessity criteria.

Payment will be approved subject to the following conditions:

- The patient must be transported to the nearest hospital with appropriate facilities.
- The patient may be transported from one hospital to another only if there is a valid documented medical reason for transporting the patient to the second hospital (as opposed to a patient's personal preference). Example: The patient requires inpatient hospital services that are not available at the first hospital.
- The patient may be transported from home or hospital to a nursing facility. On discharge from the hospital, payment will be made for ambulance service to the nursing facility where the patient is a resident.
- The patient may be transported to the outpatient department of a hospital or to a physician's office for use of specialized services. The reason the patient cannot travel independently must be documented.
- If more than one ambulance service is called to provide ground ambulance transport, payment will be made to only one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for services and supplies provided by the paramedic.

B. Medical Necessity for Emergency Transportation

Ambulance transport is indicated for emergency situations and when any other means of transport would be contraindicated (meaning they will further endanger the person's condition significantly).

Medical necessity is presumed if the record adequately documents one or more of the following:

- The patient is in an emergency situation, such as injury resulting from an accident, or illness with acute symptoms. Examples include hemorrhaging, shock, chest pain, neurologic dysfunction, and respiratory distress.
- The patient requires restraints by a professionally trained ambulance attendant. You must describe why restraints are necessary. Examples include that the patient is violent, psychotic, convulsing, or may be harmful to self or others. A simple diagnosis of senile, forgetful, Alzheimer's, etc. would not qualify.
- The patient exhibits a newly developed state of altered consciousness, such as unconsciousness or unresponsiveness. Claims for patients whose usual status is that of diminished consciousness should include documentation of the medical necessity of ambulance transport.
- The patient requires oxygen during the transport. The administration of oxygen itself does not satisfy the requirement that a patient needs oxygen. Documentation should reflect the need, such as hypoxemia, syncope, dyspnea, heart attack, chest pain, respiratory distress, pulmonary edema, carbon dioxide poisoning, shock, arrhythmia, airway obstruction, and tachypnea.

  Ambulance transport is not medically necessary if the only reason for the ambulance service is to provide oxygen during transport, and the patient has a portable oxygen system available.
- Emergency measures or treatments are indicated. Examples include drugs, IV fluids, cardiopulmonary resuscitation, cardiac monitoring, oxygen, respiratory support, and control of life threatening hemorrhage.

  The medical necessity for intravenous infusion would include the following:

  - Emergency rehydration for hypotension or shock.
  - An intravenous access route for potential use of emergency drugs.
  - An intravenous access route for actual use of indicated drugs.

Medical necessity for cardiac monitoring might include:

- Cardiac arrest.
- Cardiac rhythm disturbance
- Chest pain.
- Drug overdose with cardiotoxic drugs.
- Dyspnea not due to known lung disease.
- Electrical injury.
- Hypertensive crisis.
- Pulmonary edema.
- Serious head injury.
- Severe respiratory distress.
- Shock.
- Stroke.
- Syncope.
- Unexplained coma or unconsciousness.
- Unexplained discomfort or pain in arms, neck, or jaw.

♦ Immobilization of the patient is necessary in order to prevent complications because of a fracture that has not been set. The presence of a possible compound fracture, or the presence of severe pain, requiring immobilization or pain medication, would usually indicate the need for ambulance transport.

Simple upper-extremity fractures or ankle injuries without apparent complications generally would not require an ambulance. If there is suspicion of neurologic injury and head or spine immobilization is needed, ambulance transport is reasonable.

♦ A patient is transferred between institutions for necessary services not available at the transferring institution, and the patient meets any of the criteria listed above. Examples are patients with cardiac disease requiring cardiac catheterization or coronary bypass not available at the transferring institution, or patients requiring emergency admission for whom a bed is unavailable at the transferring institution.

C. Medical Necessity for Non-Emergency Transportation

Ambulance transport is indicated for non-emergency situations in which bed confinement is necessary before and after the ambulance trip, and a one way or round trip is for medically necessary reasons. The term "stretcher" is valid only if used to describe the movement of a bed-confined patient to an ambulance, and therefore is not a reason for transporting a patient by ambulance.

For Medicaid purposes, "bed-confined" means that a patient cannot ambulate in any way on the patient's own volition, both before and after the ambulance trip. It does not include a patient who is restricted to bed rest on physician's instructions due to short-term illness.

Other reasons to allow transport are as follows:

- There is a risk of physical injury to self or others; the patient needs restraint or needs other trained attendant.
- The patient requires ongoing intravenous medicine or fluids (and a heparin/saline lock is contraindicated).
- The patient requires oxygen and does not have a portable system.
- Isolation is required for contagious life threatening disease, such as uncontrolled bleeding in an HIV- or hepatitis-positive patient.

Round-trip ambulance service is covered for a hospital or participating skilled nursing facility inpatient to the nearest hospital or nonhospital treatment facility to obtain necessary diagnostic or therapeutic services not available at the institution where the person is an inpatient.

The round trip ambulance service benefit is subject to all existing coverage requirements and is limited to cases where the transportation of the patient is less costly than bringing the service to the patient.

D. Exclusions and Limitations on Coverage

Payment will *not* be approved for the following:

- A routine trip to return the patient home, when the patient had been transported to the hospital.
- An ambulance trip to a funeral home.
- Transfer from a hospital that has appropriate facilities and staff for treatment to another hospital. Examples include transfers to accommodate patient or family preference to receive care by a personal physician or in a particular facility.
- Transportation from one private home to another.
- Transportation of a patient from home or a nursing facility to a hospital outpatient department, unless it is established that there was an emergency or the trip was otherwise medically necessary.
- Transportation of a patient from home or a nursing facility to a hospital outpatient department for treatment that could have been performed elsewhere (such as the patient's home or nursing home).
- Transportation of a patient from home or a nursing facility to a physician's office or a freestanding or hospital-based clinic and back for routine medical care.
- Transportation of a patient to University Hospitals at Iowa City, unless it is established that the University Hospitals is the nearest hospital with facilities necessary to the care of the patient.
- Transportation of an ambulatory patient.
- Transportation to receive services of a specific physician, unless medical necessity is established.
- Transportation of, but not transfer of, an inpatient to another hospital or provider. If it is necessary to transport (but not transfer) the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for:
  - The medical treatment furnished to the patient by the other provider, and
  - The ambulance transportation between the originating hospital and the other provider.

Hospital-based ambulances transporting a patient admitted to their hospital cannot bill separately for ambulance services. These are part of the hospital's inpatient claim.

Air ambulance service is covered only when:

- The point of pick-up is inaccessible by land vehicle.
- Transportation by land ambulance is contraindicated, such as cases where great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities and speedy admission is essential.

All other conditions for coverage must also be met.

E. Transfer From One Nursing Facility to Another

It may be necessary to transfer a patient from one nursing facility to another or from a nursing facility to a custodial facility because:

- The facility is closing.
- The person no longer requires nursing care.

The county Department of Human Services office will authorize the transfer. The requirements for medical necessity and distance do not apply. The fiscal agent will approve payment without a determination of medical necessity.

Submit the regular claim form with the county office authorization attached to the Medicaid fiscal agent. Do not submit the claim to Medicare, even if the patient is a Medicare beneficiary.

When such a transfer is made, the following rate schedule applies:

One patient	Normal allowances
Two patients	3/4 normal allowance per patient
Three patients	2/3 normal allowance per patient
Four patients	5/8 normal allowance per patient

III. CODING AND PROCEDURE INSTRUCTIONS

The basis of payment is a fee schedule. **Note:** Providers must agree to accept the payment made by the Medicaid program as payment in full and make no additional charges to the recipient or others. For example, in cases where Medicaid pays only for a ground ambulance rate as opposed to the air ambulance rate, the patient cannot be billed for the remainder of this amount.

Payment will not be made on any claim where the amount of time that has elapsed between the date of service was rendered and the date the fiscal agent receives the initial claim exceeds 365 days. The fiscal agent must receive a provider's request for an adjustment to a paid claim within one year from the date of the claim was paid in order to consider the adjustment. (See Chapter F for claim instructions.)

The Health Care Financing Administration Common Procedure Coding System (HCPCS) includes specially designed codes and modifiers for reporting medical services and procedures that are copyrighted by the American Medical Association. Iowa Medicaid recognizes the following HCPC Level II codes and modifiers. Use these codes in billing for ambulance transportation:

Procedure Code	Service Description
A0225	Ambulance service, base rate, neonatal transport *
A0382	Basic life support routine disposable supplies
A0398	Advanced life support routine disposable supplies
A0420	Waiting time, one-half hour increments
A0422	Oxygen
A0424	Extra ambulance attendant (specify reason)
A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, nonemergency transport, base rate *
A0427	Ambulance service, advanced life support, emergency transport, base rate *
A0428	Ambulance service, basic life support, nonemergency transport, base rate *
A0429	Ambulance service, basic life support, emergency transport, base rate *

A0430	Ambulance service, conventional fixed-wing air services, transport one way, base rate *
A0431	Ambulance service, conventional rotary-wing air services, transport one way, base rate *
A0435	Fixed-wing air mileage, per statute mile
A0436	Rotary-wing air mileage, per statute mile

* All ambulance base rate codes require an additional two-letter modifier code. Use the first letter to identify the location of the pick-up and the second letter to identify the destination. Valid codes are as follows:

Modifier	Description
D	Diagnostic or therapeutic site other than "P" or "H" when these codes are used as origin codes
E	Residential, domiciliary, or custodial facility
G	Hospital-based dialysis facility
H	Hospital
I	Site of transfer between types of ambulance vehicles (e.g., airport or helicopter pad)
J	Non-hospital-based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician's office (includes HMO non-hospital facility, clinics, etc.)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) intermediate stop at physician's office on the way to the hospital (includes HMO non-hospital facility, clinic, etc.)

Example: An air ambulance transports a person from the scene of an accident to the hospital. The procedure code on the claim form is A0430 SH.

I. INSTRUCTIONS AND CLAIM FORM

Electronic ambulance billing is available for the following diagnosis codes:

- 994.7 Asphyxiation and strangulation: suffocation
- 427.5 Cardiac arrest
- 780.01 Coma
- 718.49 Contracture of joints of multiple sites
- 293.0 Delirium, acute
- 994.1 Drowning and nonfatal submersion
- 977.9 Drug overdose, unspecified drug or medicinal substance
- 994.0 Effects of lightning
- 994.8 Electrocution and nonfatal effects of electric current
- 991.6 Hypothermia
- 989.9 Toxic effect, unspecified substance, chiefly non-medicinal as to source
- 799.1 Respiratory arrest
- 785.50 Shock, unspecified
- 987.9 Toxic effect, unspecified gas, fumes, or vapor
- 436 Stroke

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the HCFA-1500 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**OPTIONAL** – Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED** – Enter the recipient's Medicaid ID number found on the *Medical Assistance Eligibility Card.* It should consist of seven digits followed by a letter, i.e., 1234567A.
2.	PATIENT'S NAME	**REQUIRED** – Enter the last name, first name and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification.
3.	PATIENT'S BIRTHDATE	**OPTIONAL** – Enter the patient's birth month, day, year and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	**CONDITIONAL*** – If the recipient is covered under some-one else's insurance, enter the name of the person under which the insurance exists. This could be insurance covering the recipient as a result of a work or auto related accident. **Note:** This section of the form is separated by a border, so that information on this other insurance follows directly below, even though the numbering does not.
5.	PATIENT'S ADDRESS	**OPTIONAL** – Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**CONDITIONAL*** – If the recipient is covered under another person's insurance, mark the appropriate box to indicate relation.
7.	INSURED'S ADDRESS	**CONDITIONAL*** – Enter the address and phone number of the insured person indicated in field number 4.
8.	PATIENT STATUS	**OPTIONAL** – Check boxes corresponding to the patient's current marital and occupational status.

9a-d.	OTHER INSURED'S NAME	**CONDITIONAL*** – If the recipient carries other insurance, enter the name under which that insurance exists, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program.
10.	IS PATIENT'S CONDITION RELATED TO	**CONDITIONAL*** – Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work or accident related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "YES" and "NO" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL** – No entry required.

11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**CONDITIONAL*** – This field continues with information related to field 4. If the recipient is covered under someone else's insurance, enter the policy number and other requested information as known.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**CONDITIONAL** – If payment has been received from another insurance, or the medical resource codes on the eligibility card indicate other insurance exists, check "YES" and enter payment amount in field 29. If you have received a denial of payment from another insurance, check both "YES" and "NO" to indicate that there is other insurance, but that the benefits were denied. **Note:** Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
14.	DATE OF CURRENT ILL-NESS, INJURY, PREGNANCY	**CONDITIONAL*** – Chiropractors must enter the date of the onset of treatment as month, day and year. All others – no entry required.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS…	**CONDITIONAL** – Chiropractors must enter the current x-ray date as month, day and year. All others – no entry required.
16.	DATES PATIENT UNABLE TO WORK…	**OPTIONAL** – No entry required.

17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**CONDITIONAL** – Required if the referring physician does not have a Medicaid number.
17a.	ID NUMBER OF REFERRING PHYSICIAN	**CONDITIONAL*** – If the patient is a MediPASS recipient and the MediPASS physician authorized service, enter the seven-digit MediPASS authorization number. If this claim is for consultation, independent lab or DME, enter the Iowa Medicaid number of the referring or prescribing physician. If the patient is on lock-in and the lock-in physician authorized service, enter the seven-digit authorization number.
18.	HOSPITALI-ZATION DATES RELATED TO…	**OPTIONAL** – No entry required.
19.	RESERVED FOR LOCAL USE	**REQUIRED** – If the patient is pregnant, write "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** – No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** – Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary; 2-secondary; 3-tertiary; and 4-quaternary) to a maximum of four diagnoses.
22.	MEDICAID RESUBMISSION CODE…	**OPTIONAL** – No entry required.
23.	PRIOR AUTHORIZATION NUMBER	**CONDITIONAL*** – Enter the prior authorization number issued by Consultec.

24. A	DATE(S) OF SERVICE	**REQUIRED** – Enter month, day and year under both the From and To categories for each procedure, service or supply. If the From-To dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	**REQUIRED** – Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility – partial hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-stage Renal Disease Treatment 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility

24. C	TYPE OF SERVICE	**OPTIONAL** – No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** – Enter the appropriate five-digit procedure code and any necessary modifier for each of the dates of service. DO NOT list services for which no fees were charged.
24. E	DIAGNOSIS CODE	**REQUIRED** – Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., 3. DO NOT write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED** – Enter the usual and customary charge for each line item.
24. G	DAYS OR UNITS	**REQUIRED** – Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**OPTIONAL*** – Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	EMG	**OPTIONAL** – No entry required.
24. J	COB	**OPTIONAL** – No entry required.
24. K	RESERVED FOR LOCAL USE	**CONDITIONAL*** – Enter the treating provider's individual seven-digit Iowa Medicaid provider number when the provider number given in field 33 is that of a group and/or is not that of the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** – No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.

27.	ACCEPT ASSIGNMENT?	**OPTIONAL** – No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** – Enter the total of the line item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**CONDITIONAL*** – Enter only the amount paid by other insurance. Recipient co-payments, Medicare payments or previous Medicaid payments are not listed on this claim.
30.	BALANCE DUE	**REQUIRED*** – Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** – The signature of either the physician or authorized representative and the original filing date must be entered. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	NAME AND ADDRESS OF FACILITY…	**CONDITIONAL** – If other than a home or office, enter the name and address of the facility where the service(s) were rendered.
33.	PHYSICIAN'S, SUPPLIER'S BILLING NAME…	**REQUIRED*** – Enter the complete name and address of the billing physician or service supplier.
	GRP #	**REQUIRED** – Enter the seven-digit Iowa Medicaid number of the billing provider. If this number identifies a group or an individual provider other than the provider of service, the treating provider's Iowa Medicaid number must be entered in field 24K for each line.
BACK OF FORM	NOTE	**REQUIRED** – The back of the claim form must be intact on every claim form submitted.

B. Facsimile of Claim Form, HCFA-1500 (front and back)

(See the following pages.)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRI

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO **If yes**, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

II. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See the following pages.)

MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE 06/12/97

REMITTANCE ADVICE

(1.) TO: [redacted] (2.) R.A. NO.: 0000006 (3.) DATE PAID: 05/19/97 (4.) PROVIDER NUMBER: [redacted] (5.) PAGE: 1

**** PATIENT NAME **** LAST	FIRST MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* (6.) CLAIM TYPE: HCFA 1500						* (7.) CLAIM STATUS: PAID							
ORIGINAL CLAIMS:			(10.)			(11.)	(12.)	(13.)	(14.)	(15.)		(16.)	
[redacted] (8.)	[redacted]	(9.) [redacted]	4-96331-00-053-0038-00			38.00	0.00	16.06	0.00	8606006088		900	000
		(17.) 01	(18.) 10/3	(19.) 99212	(20.) 1	(21.) 38.00	(22.) 0.00	(23.) 16.06	(24.) 0.00	(25.) [redacted]			000 000
[redacted]	[redacted]	[redacted]	4-96348-00-018-0060-00			50.00	0.00	35.26	0.00	8606006088			000 000
		01	11/15/96	J1055	1	41.00	0.00	33.18	0.00	[redacted]	(26.)	F	000 000
		02	11/15/96	9C782	1	9.00	0.00	2.08	0.00	[redacted]		F	000 000

(27.)

REMITTANCE TOTALS					
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	2	---------	88.00	51.32
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	---------	0.00	0.00
AMOUNT OF CHECK:					51.32

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

(28.) 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

Page 14 was intentionally left blank.

C. Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.

2. *Remittance Advice* number.

3. Date claim paid.

4. Billing provider's Medicaid (Title XIX) number.

5. *Remittance Advice* page number.

6. Type of claim used to bill Medicaid.

7. Status of following claims:

   - **Paid** – claims for which reimbursement is being made.
   - **Denied** – claims for which no reimbursement is being made.
   - **Suspended** – claims in process. These claims have not yet been paid or denied.

8. Recipient's last and first name.

9. Recipient's Medicaid (Title XIX) number.

10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.

11. Total charges submitted by provider.

12. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.

13. Total amount of Medicaid reimbursement as allowed for this claim.

14. Total amount of recipient copayment deducted from this claim.

15. Medical record number as assigned by provider; 10 characters are printable.

16. Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of *Remittance Advice* for explanation of the EOB code.

17. Line item number.

18. The first date of service for the billed procedure.

19. The procedure code for the rendered service.

20. The number of units of rendered service.

21. Charge submitted by provider for line item.

22. Amount applied to this line item from other resources, i.e., other insurance, spenddown.

23. Amount of Medicaid reimbursement as allowed for this line item.

24. Amount of recipient copayment deducted for this line item.

25. Treating provider's Medicaid (Title XIX) number.

26. Allowed charge source code:

B Billed charge
F Fee schedule
M Manually priced
N Provider charge rate
P Group therapy
Q EPSDT total screen over 17 years
R EPSDT total under 18 years
S EPSDT partial over 17 years
T EPSDT partial under 18 years
U Gynecology fee
V Obstetrics fee
W Child fee

27. Remittance totals (found at the end of the *Remittance Advice*):

- Number of paid original claims, the amount billed by the provider and the amount allowed and reimbursed by Medicaid.
- Number of paid adjusted claims, amount billed by provider and amount allowed and reimbursed by Medicaid.
- Number of denied original claims and amount billed by provider.
- Number of denied adjusted claims and amount billed by provider.
- Number of pended claims (in process) and amount billed by provider.
- Amount of check.

28. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

III. FACSIMILE OF MEDICAID CLAIM DENIAL NOTICE, FORM 470-0385

The *Medicaid Claim Denial Notice*, form 470-0385, informs the recipient or a representative of the recipient when claims for ambulance services are denied for reasons other than problems with claim completion. A facsimile is provided for your information, since the recipient may contact you with questions concerning this notice.

(See page 19.)

Page 18 was intentionally left blank.

IOWA DEPARTMENT OF HUMAN SERVICES
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA 50319-0114
MEDICAID CLAIM DENIAL NOTICE

THIS IS NOT A BILL

MM/DD/YY DENIAL NOTICE NO.: YYDDD-999999

_____
_____
_____
_____

DEAR _____:

THE MEDICAID CLAIMS LISTED BELOW FOR _____, _____, WERE DENIED FOR PAYMENT UNDER THE IOWA MEDICAID PROGRAM:

PROVIDER NUMBER: _____
PROVIDER NAME : _____

TCN: YYDD-999-9999999-99
DATE OF SERVICE : MM/DD/YY
SERVICE PROVIDED : _____
AMOUNT BILLED : $99,999.99
REASON FOR DENIAL : _____
_____
_____
_____

MANUAL REFERENCE: EMPLOYEES' MANUAL, TITLE 8, APPENDIX,
_____ AGENCY, CHAPTER E, COVERAGE OF SERVICE.

SINCE THESE SERVICES WERE NOT PAYABLE BY THE MEDICAID PROGRAM, YOU MAY BE ASKED TO PAY FOR THEM.

YOUR RIGHTS OF APPEAL ARE EXPLAINED ON THE BACK OF THIS NOTICE.

SINCERELY,
IOWA MEDICAID PROGRAM

RIGHT OF APPEAL

If you do not agree with the action taken to deny Medicaid payment for the claim submitted, you have the right to appeal. Your appeal rights and procedures for hearing are explained in the 441 Iowa Administrative Code, Chapter 7, and 481 Iowa Administrative Code, Chapter 10.

How to Appeal. You must appeal in writing. You may use the Department of Human Services' appeal form or you may simply send a letter asking to appeal. Attach a copy of this notice to your appeal. Send or take the appeal to the following address:

Appeals Section
Iowa Department of Human Services
Hoover State Office Building, Fifth Floor
Des Moines, Iowa 50319-0114

Your county Department of Human Services office will assist you in filing an appeal if you ask them. There is no fee or charge for an appeal. (See **Time Limits** below.)

Time Limits. You must appeal within 30 calendar days or before the effective date of this notice, whichever is longer, to be assured of a hearing. When the appeal is filed late (that is, more than 30 calendar days, but, less than 90 calendar days after the date of this notice) the Director of the Department of Human Services must approve whether a hearing shall be granted, based on a good cause for late filing. Any discussion between you and the Department does not extend these time periods. No hearing shall be granted if the appeal is filed more than 90 days from the date of this notice.

Granting a Hearing. The Department of Human Services will determine whether or not an appeal may be granted hearing. If a hearing is granted, you will be notified of the time and place. However, a hearing need not be granted if the appeal is not eligible to be heard. If no hearing is granted, you will be notified of the reason.

Presenting Your Case. If a hearing is granted to your appeal, you may explain your disagreement or have someone else, like a relative or friend, explain your disagreement for you. If you wish, you may be represented by an attorney, but the Department cannot pay the attorney. Your worker has information about legal services based on ability to pay that may be available to you. You may also phone Legal Services Corporation of Iowa at 1-800-532-1275. If you live in Polk County, phone Polk County Legal Aid at 243-1193.

POLICY ON NONDISCRIMINATION

This action was taken without regard to race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief. If you have reason to believe that you may have been discriminated against due to any of the reasons stated above, you may file a complaint with the Iowa Department of Human Services (DHS) by completing a Discrimination Complaint form. Any DHS office, institution, or the Office of Equal Opportunity can give you a form. You may also file a complaint with the Iowa Civil Rights Commission (if you feel you were treated differently BECAUSE OF your race, creed, color, national origin, sex, religion or disability); or the United States Department of Health and Human Services, Office for Civil Rights.

Iowa Department of Human Services
Office of Equal Opportunity
Hoover State Office Building 5th Fl
Des Moines IA 50319-0114

US Department of Health and Human Services
Office for Civil Rights Region VII
601 E 12th St Rm 248
Kansas City MO 64106

Iowa Civil Rights Commission
Grimes State Office Bldg
211 E Maple St 2nd Fl
Des Moines IA 50309-1858

470-0385 (Rev. 5/98)

IV. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

Consultec, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- A paid claim amount needs to be changed, or
- Money needs to be credited back, or
- An entire *remittance advice* should be canceled.

Send this form to:

Consultec, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program

PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: ❒ Claim copy ❒ Remittance copy
❑ Other pertinent information for possible claim reprocessing.

INQUIRY A

1. 17-DIGIT TCN

2. NATURE OF INQUIRY

(Please do not write below this line)
FOR CONSULTEC RESPONSE

INQUIRY B

1. 17–DIGIT TCN

2. NATURE OF INQUIRY

(Please do not write below this line)
FOR CONSULTEC RESPONSE

Provider Signature/Date:	**MAIL TO: CONSULTEC P. O. BOX 14422 DES MOINES IA 50306-3422**	**Consultec Signature/Date:**

Provider Please Complete:

7-digit Medicaid Provider ID#_____

Telephone_____

Name
Street
City, St
Zip

(FOR CONSULTEC USE ONLY)

PR Inquiry Log #_____

Received Date Stamp:

Page 24 was intentionally left blank.

Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

SECTION A: Check the most appropriate action and complete steps for that request.

❑ CLAIM ADJUSTMENT	❑ CLAIM CREDIT	❑ CANCELLATION OF ENTIRE REMITTANCE ADVICE
♦ Attach a complete copy of claim. (If electronic, use next step.) ♦ Attach a copy of the Remittance Advice with corrections in **red ink**. ♦ Complete Sections B and C.	♦ Attach a copy of the Remittance Advice. ♦ Complete Sections B and C.	♦ Use only if all claims on Remittance Advice are incorrect. This option is rarely used. ♦ Attach the check and Remittance Advice. ♦ Skip Section B. Complete Section C.

SECTION B:

1. 17-digit TCN

2. Pay-to Provider #:

4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A)

3. Provider Name and Address:

5. Reason for Adjustment or Credit Request:

SECTION C:

Provider/Representative Signature:

Date:

CONSULTEC USE ONLY: REMARKS/STATUS

Return All Requests To:

Consultec
PO Box 14422
Des Moines, IA 50306-3422

March 15, 1996

For Human Services Use Only

General Letter No. 8-A-AP(II)-581

Subject: Employees' Manual, Title VIII, Chapter A, Appendix, Part Two

AMBULANCE SERVICES MANUAL TRANSMITTAL NO. 96-1

Subject: ***Ambulance Services Manual***, Table of Contents, page 4, revised; Chapter E, *Coverage and Limitations*, pages 1 through 6, revised; and page 7, new.

Chapter E transmits revisions reflecting updated format, limitations on paramedic services, and updated procedure codes and service descriptions for billing for ambulance transportation.

Date Effective

March 1, 1996

Material Superseded

Remove from the Ambulance Services Manual, Table of Contents, pages 4 and 5, dated March 1, 1994, and Chapter E, pages 1 through 6, dated April 1, 1991.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to UNISYS, fiscal agent for the Department of Human Services.

DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-65
Employees' Manual, Title 8
Medicaid Appendix

May 22, 1998

AMBULANCE SERVICES MANUAL TRANSMITTAL NO. 98-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Ambulance Services Manual***, Table of Contents (page 4), revised; Chapter F, *Billing and Payment*, pages 1 through 19, revised; and page 20, new.

Chapter F is revised to update billing and payment instructions.

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from the ***Ambulance Services Manual***, and destroy them:

Page	Date
Contents (page 4)	March 1, 1996
Chapter F	
1, 2	March 1, 1994
3, 4	2/93
5-11	March 1, 1994
12	Undated
13-15	09/30/79
16-18	March 1, 1994
19	3/94

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

For Human Services use only:

General Letter No. 8-AP-133
Employees' Manual, Title 8
Medicaid Appendix

Iowa Department of Human Services

February 18, 2000

AMBULANCE SERVICES MANUAL TRANSMITTAL NO. 00-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Ambulance Services Manual***, Table of Contents (page 4), revised; Chapter E, *Coverage and Limitations*, pages 1 through 7, revised; and pages 8 and 9, new; Chapter F, *Billing and Payment*, pages 1 and 2, revised, and page 2a, new.

Chapter E is updated to:

- Explain the basic and advanced life support services.
- Expand the definition of medical necessity.
- Break out medical necessity for emergency and nonemergency medical transportation.
- Stress the importance for the ambulance provider to provide adequate documentation on claims in order to receive payment.
- Remove form MA-3003-6, *Authorization for Medical Assistance*, as this form is obsolete.
- Update the procedure codes to conform to HCPCS coding.
- List modification codes for ambulance providers.

The changes from current codes to new codes are listed below:

New Code	Current Code	New Code	Current Code
A0360	A0010	A0398	A0215
A0362	A0010	A0420	A0060
A0364	A0220	A0424	Y0012
A0366	A0220	A0422	A0070
A0368	A0220	A0380	A0020
A0370	A0220	A0390	A0020
A0382	A0215		

Chapter F is revised to add a list of diagnosis codes for which the fiscal agent accepts electronic ambulance billing.

Date Effective

February 1, 2000

Material Superseded

Remove the following pages from the ***Ambulance Services Manual***, and destroy them:

Page	Date
Contents (page 4)	May 1, 1998
Chapter E	
1-7	March 1, 1996
Chapter F	
1, 2	May 1, 1998

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-165
Employees' Manual, Title 8
Medicaid Appendix

March 16, 2001

AMBULANCE SERVICES MANUAL TRANSMITTAL NO. 01-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***AMBULANCE SERVICES MANUAL***, Table of Contents (page 4), revised; Chapter E, *Coverage and Limitations*, pages 8 and 9, revised; and Chapter F, *Billing and Payment*, pages 21 through 25, new.

Chapter E is updated to reflect reorganization and renumbering of ambulance service codes:

- Codes for advanced life support with and without specialized services have been combined.
- Separate codes are identified for ground mileage, fixed-wing air transport mileage, and rotary-wing air transport mileage.

The changes from current codes to new codes are listed below:

Current Code	New Code	Current Code	New Code
A0030	A0430	A0368	A0427
A0040	A0431	A0370	A0427
A0360	A0428	A0380	A0425
A0362	A0429	A0390	A0425
A0364	A0428	W0109	A0435 or A0436
A0366	A0426		

Chapter F is revised to update billing and payment instructions by providing for an inquiry process for denied claims or if claim payment was not in the amount expected. Two forms are added: 470-3744, *Provider Inquiry*; and 470-0040, *Credit/Adjustment Request*.

Complete the *Provider Inquiry* if you wish to inquire about a denied claim or if claim payment was not as expected. Complete the *Credit/Adjustment Request* to notify Consultec that: a paid claim amount needs to be changed; or funds need to be credited back; or an entire *Remittance Advice* should be canceled.

Date Effective

January 1, 2001

Material Superseded

Remove from the ***AMBULANCE SERVICES MANUAL***, Table of Contents, page 4, and Chapter E, pages 8 and 9, all dated January 1, 2000, and destroy them.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.